MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 C-D, Film G249 10/2/59 jwk

10710

CERTIFICATE OF DEATH

10696

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Maugansville Hagerstown
d. STREET ADDRESS: 6 Hager Street Mennonite Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle MAE Last ALLEN
4. DATE OF DEATH: Month September Day 18 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: March 12 1880
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Bedington Berkley Co W. Va
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas LeDane
14. MOTHER'S MAIDEN NAME: Rosella Pearl
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Lawrence Glover Address: Sunrise Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Maugansville Md.

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Chronic congestive heart failure	12 years
DUE TO (b)	arteriosclerotic, hypertensive and rheumatic heart disease	12 years / unknown
DUE TO (c)		

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 4, 19 47, to Sept. 18, 1959, that I last saw the deceased alive on Sept. 17, 1959, and that death occurred at 8:20 A M, DST, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. T. Layman M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. — DATE SIGNED: 9/19/59

PHYSICIAN'S NAME (Type): William T. Layman — Hagerstown — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/20/59
22c. NAME OF CEMETERY OR CREMATORY: Spring Mills Cemetery
22d. LOCATION (City, town, or county) (State): Falling Waters Berkley Co W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: SEP 25 '59
24b. REGISTRAR'S SIGNATURE: Coffman & Kuns

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10711 — 10697 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 35 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 725 Sunset Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 725 Sunset Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOMER — Middle CLEVELAND — Last AMOS

4. DATE OF DEATH: Month September — Day 26 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 5 1887

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber Retired

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Waynesburg Greene Co Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Amos

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.# 1

16. SOCIAL SECURITY NO.: 217-32-5625

17. INFORMANT: Andrew A. Amos — Address: 1025 Rose Hill Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)		
DUE TO (b)	Hypertensive Cardio Vascular Dis	5 yrs
DUE TO (c)		

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: A. Ed Coffman M.D.

EXAMINER'S NAME (Type): ARTHUR E. COFFMAN JR.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9/28/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/29/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: OCT 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10698

CERTIFICATE OF DEATH

10762

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 1yr-11mos-1wk
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylavania
b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Fayettville
d. STREET ADDRESS: R.F.D. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): Dr. Benjamin A. Barney
4. DATE OF DEATH: September 19 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept 16, 1872
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical Doctor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Independence, Newyork
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Jonathan O. Barney
14. MOTHER'S MAIDEN NAME: Lillie Dexter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
INFORMANT: Mrs. Marion Howard Address: Fayettville, Rt. 1 Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 15 mos
DUE TO (b): Atherosclerosis - gen debility — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1958 to Sept 19, 1959, that I last saw the deceased alive on Sept 4, 1959, and that death occurred at 7 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M E Byrkit M.D. ADDRESS (Street, city or town, state): 28 W Potomac DATE SIGNED: 9-19-59
PHYSICIAN'S NAME (Type): Max E Byrkit Williamsport Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/22/1959
22c. NAME OF CEMETERY OR CREMATORY: Canisteo Cemetery
22d. LOCATION (City, town, or county) (State): Steuben Co., New York

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home P. Franklin Rouzer ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE SEP 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10713

CERTIFICATE OF DEATH

10693

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 419 George Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LISA; Middle KOREN; Last BLEVINS

4. DATE OF DEATH: Month September; Day 14; Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 2, 1958

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months 11; Days; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Archie Blevins

14. MOTHER'S MAIDEN NAME: Shirley Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Archie Blevins — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Aspiration Pneumonitis	12 hr
591.0 DUE TO (b)	Dehydration	4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Gastroenteritis	8 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/11/59, to 9/14/59, that I last saw the deceased alive on 9/14/59, and that death occurred at 12 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard A. Young M.D. — ADDRESS (Street, city or town, state): 101 King Street — DATE SIGNED: 9/14/59

PHYSICIAN'S NAME (Type): Richard A. Young — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/16/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

208122XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10714

CERTIFICATE OF DEATH

Reg. Dist. No. 10760

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 212 SUMMER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORMAN — Middle JACOB — Last BOWERS

4. DATE OF DEATH: Month SEPT. — Day 29 — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/8/1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY: TENANT FARM

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE BOWERS

14. MOTHER'S MAIDEN NAME: SUSAN BAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

INFORMANT: MRS. MILDRED MORRISON — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonia - ? abscess formation (multiple ? bronchial lung) — INTERVAL BETWEEN ONSET AND DEATH: 10 days
600.0
DUE TO (b): myelomeplastic - left + wrist — unkn.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): renal calculi

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign prostate

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 7, 1959, to Sept 29, 1959, that I last saw the deceased alive on Sept 28, 1959, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto III M.D. — ADDRESS (Street, city or town, state): 217 W. Washington St. — DATE SIGNED

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M.D. Hagerstown, Maryland 9/30/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/2/59
22c. NAME OF CEMETERY OR CREMATORY: MANOR CHURCH CEM.
22d. LOCATION (City, town, or county) (State): WASHINGTON CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR — DATE: OCT 5 '59
24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10715

CERTIFICATE OF DEATH

Reg. Dist. No. 10701

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 9 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): A YARROWSBURG
d. STREET ADDRESS: KNOXVILLE MD. R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle HOWARD Last CARTER

4. DATE OF DEATH: Month SEPTEMBER Day 16 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 12 1892

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR Months 11 Days 4 IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: B.&O.R.R Co.

11. BIRTHPLACE (State or foreign country): YARROWSBURG WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY? MD. U.S.A

13. FATHER'S NAME: ISAAC CARTER

14. MOTHER'S MAIDEN NAME: MARY HOFFMASTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-07-1574

17. INFORMANT Address: MRS. ELLEN M. CARTER KNOXVILLE MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO (b): (Middle Cerebral Artery)
DUE TO (c): Hypertensive Cardio Vascular Disease — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4439

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 12, 19 59, to Sept 16, 19 59, that I last saw the deceased alive on Sept 12, 19 59, and that death occurred at 4:42 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W Ditto III M.D. ADDRESS (Street, city or town, state): 212 W. Washington St DATE SIGNED: Sept 17, 59

PHYSICIAN'S NAME (Type): Edward W Ditto III Hagerstown MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT. 18, 1959

22c. NAME OF CEMETERY OR CREMATORY: BROWNSVILLE CEMETERY

22d. LOCATION (City, town, or county) (State): BROWNSVILLE WASH. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John N. Frost ADDRESS: BOONSBORO MD.

24a. REC'D BY REGISTRAR DATE: SEP 21 59

24b. REGISTRAR'S SIGNATURE: Arthur L. Mann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10702

10763

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 2
c. LENGTH OF STAY IN 1b: 5 Mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Conv. Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 652 No Prospect St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WARREN; Middle: SOLOMON; Last: CLOUSTON

4. DATE OF DEATH: Month: Sept; Day: 19; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 13 1908

9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): W. Va. Beaver Randolph Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugh Clouston

14. MOTHER'S MAIDEN NAME: Nancy Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes W.W. 2 Navy

16. SOCIAL SECURITY NO.: 230-[illegible]

17. INFORMANT: Mrs Eva Ridenour 652 No Prospect St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 or 2 Yrs.
DUE TO (b): Cerebral Hemorrhage — 3 mo
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 6, 19 59, to Sept 17, 19 59, that I last saw the deceased alive on Sept 19, 19 59, and that death occurred at 5 30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D.
ADDRESS (Street, city or town, state): 159 W. Washington St. Hagerstown, Md.
DATE SIGNED: 9/19/59

PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/21/59
22c. NAME OF CEMETERY OR CREMATORY: Long Meadows Cemetery
22d LOCATION (City, town, or county) (State): Paramount Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a REC'D BY REGISTRAR DATE: SEP 25 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10764 **CERTIFICATE OF DEATH** Reg. Dist. No. 10703

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GATEWAY CONV. HOME

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 801 HAMILTON BLVD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVA — Middle FRANCES — Last CURREY

4. DATE OF DEATH: Month SEPTEMBER — Day 23 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/14/1873

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PHILIP H. BLOOM

14. MOTHER'S MAIDEN NAME: MARY RECK

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: 215-14-1583

INFORMANT: MRS. NETTIE V. WILSON — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Briast — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
170X
DUE TO (b): with Metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 30, 1959 to Sept 23, 1959, that I last saw the deceased alive on Sept 22, 1959 and that death occurred at 3:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D. — ADDRESS (Street, city or town, state): Clear Spring Md — DATE SIGNED: 9/25/59

PHYSICIAN'S NAME (Type): David R. Brewer

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9/25/59

22c NAME OF CEMETERY OR CREMATORY: UNION BRIDGE CEM.

22d. LOCATION (City, town or county) (State): UNION BRIDGE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment — ADDRESS: Hagerstown Md

24a. REC'D BY REGISTRAR DATE: SEP 28 '59

24b. REGISTRAR'S SIGNATURE: Carlton S Kreps

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10716

CERTIFICATE OF DEATH

10704

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 308 N. Locust Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERT Middle NELSON Last DEAL

4. DATE OF DEATH: Month September Day 27 Year 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1902

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roundhouse Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Deal

14. MOTHER'S MAIDEN NAME: Mary Byrnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-10-5958

17. INFORMANT: Mrs. Pauline Deal — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Carcinoma Prostate — 1 yr.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ____ o. m. p. m. Month ____ Day ____ Year 19____

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 18, 1958, to Sept 27th, 1959, that I last saw the deceased alive on 9/27/59, 19____, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. G. Warden, M. D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): J. G. Warden, M. D. — 832 Potomac Ave., Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/30/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md,

24a. REC'D BY REGISTRAR DATE: OCT 2 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Kinsey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10717

CERTIFICATE OF DEATH

Reg. Dist. No. 10705

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. b. COUNTY: Wash.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 43 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital
d. STREET ADDRESS: 138 S. Prospect St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Maude; Middle: ; Last: Deavers
4. DATE OF DEATH: Month: Sept. Day: 19 Year: 19 59

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 24, 1894
9. AGE (In years last Birthday): 64 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): kitchen work
10b. KIND OF BUSINESS OR INDUSTRY: hotel
11. BIRTHPLACE (State or foreign country): Brunswick, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Edward Rockwell
14. MOTHER'S MAIDEN NAME: Josephine Detrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-14-7590
INFORMANT: Walter A. Deavers, Hagerstown, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: unknown
170X
DUE TO (b): Carcinoma of breast — 2 yr +
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO (c): (Pagets Disease of the Breast)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 15, 19 57, to Sept 19, 19 59 that I last saw the deceased alive on Sept 19, 19 59, and that death occurred at 3:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L L Packer Jr M.D. — ADDRESS (Street, city or town, state): 145 W. Washington — DATE SIGNED: 9/21/59
PHYSICIAN'S NAME (Type): L. L. Packer Jr — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-21-59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemeteyr
22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: SEP 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10706

10718

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 20 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegheny
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Apt. 38 Frederick St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Paul Last: Edmondson

4. DATE OF DEATH: Month: Sept. Day: 5 Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 20, 1912

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Charles Edmondson

14. MOTHER'S MAIDEN NAME: Mary Fields

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

INFORMANT: Mary Washington (sister) Same — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 13 days

DUE TO (b): Neurosyphilis, congenital — 46 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

020.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Dec. 17, 1957, to Sept. 5, 1959, that I last saw the deceased alive on Sept. 5, 1959, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor L. Ramos, M.D. — ADDRESS (Street, city or town, state): Western Maryland State Hosp. — DATE SIGNED: Sept. 5, 1959

PHYSICIAN'S NAME (Type): Victor L. Ramos, M.D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-8-59

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Burial Park

22d LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hafer Funeral Service Cumberland Md — ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 9 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10719

CERTIFICATE OF DEATH

10707
Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 11 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1032 So Colonial Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle CAMERON — Last ELGIN

4. DATE OF DEATH: Month September — Day 19 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 28 1892
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Beaverton Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Elgin
14. MOTHER'S MAIDEN NAME: Fannie Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. I
16. SOCIAL SECURITY NO: 214-09-9772
17. INFORMANT — Address: Cameron E. Elgin 1032 So Colonial Dr Hagertown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteria Sclerotic Heart Disease	4 yrs
DUE TO (b)	Emphysema	10 yrs
DUE TO (c)	Bronchial Asthma	10 yrs

241X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 59, to Sept 19 59, that I last saw the deceased alive on Sept 19 59, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Elden D Hoachlander M.D. — ADDRESS (Street, city or town, state): 115 W Wash St — DATE SIGNED: 9/21/59

PHYSICIAN'S NAME (Type): Elden D Hoachlander — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/22/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: SEP 25 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10720

Reg. Dist. No. 10708

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 17 DUNN IRVIN DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle JONAS — Last FLOOK

4. DATE OF DEATH: Month SEPT. — Day 15 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/10/1886

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FIRE TRUCK DRIVER

10b. KIND OF BUSINESS OR INDUSTRY: CITY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JONAS T. FLOOK

14. MOTHER'S MAIDEN NAME: ANNA SHOEMAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

INFORMANT: MRS. CLARA S. FLOOK — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of the colon with intestinal obstruction
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

153.8

INTERVAL BETWEEN ONSET AND DEATH: Not known

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 21, 1959 to Sept. 15, 1959 that I last saw the deceased alive on September 15, 1959, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D. — ADDRESS (Street, city or town, state): 148 West Washington St. — DATE SIGNED: 9/16/59

PHYSICIAN'S NAME (Type): Dr. B. B. Kneisley, Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9/18/59

22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. J. Kennett, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: SEP 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Frana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10710 Reg. Dist. No.

10721

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland
d. STREET ADDRESS 4323 Brooks Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First DELLA Middle M. Last FOWLER

4. DATE OF DEATH Month SEPTEMBER Day 3 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 12-16-1882
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Jarman
14. MOTHER'S MAIDEN NAME Mary Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
INFORMANT Joseph Jarman Address 4323 Brooks Drive Suitland Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH 4 days

194X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) CARCINOMA of thyroid, METASTATIC LOCALLY. — 9 Months

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE 13, 1959, to SEPT 3, 1959, that I last saw the deceased alive on SEPT. 3, 1959, and that death occurred at 9:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Evaristo R. Lardizabal M.D. ADDRESS (Street, city or town, state) 1500 Pennsylvania Ave DATE SIGNED 9-3-59

PHYSICIAN'S NAME (Type) EVARISTO R. LARDIZABAL Hagerstown, Md

22a. BURIAL, CREMATION REMOVAL (Specify) Burial
22b DATE THEREOF 9-6-1959
22c. NAME OF CEMETERY OR CREMATORY Christ Home
22d. LOCATION (City, town, or county) (State) Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE John A. Mattingly ADDRESS 731-11 St N.W. Wash, DC
24a. REC'D BY REGISTRAR DATE SEP 8 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10722

10709
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 130 N.Mulberry St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: DAVID Middle: LEE Last: FOX

4. DATE OF DEATH Month: Sept. Day: 15 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept.14,1959
9. AGE (In years last birthday) yrs.: — IF UNDER 1 YEAR Months: — Days: 2 IF UNDER 24 HRS. Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Hagerstown,Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howard L.Fox
14. MOTHER'S MAIDEN NAME: Audrey J.McManus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mr.Howard L.Fox 130 N.Mulberry St.Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia and/or aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2

762.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Poor regulation of vital centers
DUE TO (c) Maternal cause, Ruptured uterus at 34 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Birth, 19____, to death, 19____, that I last saw the deceased alive on 9-15, 1959, and that death occurred at 9:18 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert F. Keadle M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED: 9/16/59

PHYSICIAN'S NAME (Type): Robert F.Keadle M.D. 318 N.Potomac St. Hagerstown,Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/18/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md.
24a. REC'D BY REGISTRAR DATE: SEP 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur & Evans

20813

TO HOSPITAL [redacted] ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hou[redacted]fter death: Page 4 may be reta[redacted]y the hospital or attending physician.
TO FUNERAL [redacted]: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shou[redacted] detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar [redacted]ior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10711

10723 Item 8 Film 9-10-59 ed

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: 13 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland Chronic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Blue Ridge Summit Pa.

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EVALYN — Middle: LUCRETA — Last: FRAZER

4. DATE OF DEATH: Month: SEPTEMBER — Day: 10 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/22/1889

9 AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Steubenville Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Myers

14. MOTHER'S MAIDEN NAME: Margaret Brandt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT — Address: Mrs. Dorothy McCleaf, Blue Ridge Summit Pa.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 WEEK

DUE TO (b): Pyelonephritis — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchiectasis Hyper-Tensive Cardio-Vascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 28, 1959, to Sept. 10, 1959, that I last saw the deceased alive on Sept 9, 1959, and that death occurred at 4:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Evaristo R. Lardizabal M.D. — ADDRESS (Street, city or town, state): 1500 Pennsylvania Ave — DATE SIGNED: 9-10-59

PHYSICIAN'S NAME (Type): EVARISTO R. LARDIZABAL Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/13/59

22c. NAME OF CEMETERY OR CREMATORY: Broadfording

22d. LOCATION (City, town, or county) (State): Hagerstown #5, Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Walter Y. Grove, Waynesboro Pa.

24a. REC'D BY REGISTRAR DATE: SEP 1 [illegible] '59

24b. REGISTRAR'S SIGNATURE: Carlton L. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours [illegible] death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10724

CERTIFICATE OF DEATH

10712 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1 Interval Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: Laura — Last: Harvey

4. DATE OF DEATH: Month: 9 — Day: 24 — Year: 1959

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 26, 1912
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Thomas, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abe Harsh
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 220-30-8166
INFORMANT: Mrs. Betty Doub — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of uterus — INTERVAL BETWEEN ONSET AND DEATH: 6 mos +
DUE TO
174X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized abd. metastases; fulm. emboli; thrombophlebitis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 Feb 1959 to 24 Sept 1959, that I last saw the deceased alive on 24 Sept 1959, and that death occurred at 11.30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford M.D. — ADDRESS (Street, city or town, state): 1135 Potomac Avenue — DATE SIGNED: 26 Sept. 59

PHYSICIAN'S NAME (Type): Richard T. Binford, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 9-28-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Fred W. Kraiss Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: SEP 29 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuhns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10725

CERTIFICATE OF DEATH

10713

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: [illegible]-4023 Jones Bridge Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible], Middle Joseph P, Last Hipkins
4. DATE OF DEATH: Month September, Day 19, Year 1959

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 27, 1897
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Electric
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Hipkins
14. MOTHER'S MAIDEN NAME: Pearl Music

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT: Hospital record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Mesenteric vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days

153.2

DUE TO (b): Carcinoma of descending colon

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Left hemiplegia secondary to cerebral thrombosis; Pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 15, 1959 to Sept. 19, 1959, that I last saw the deceased alive on Sept. 18, 1959, 19____, and that death occurred at 3:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank E Brumback M.D. — ADDRESS (Street, city or town, state): 170 W. Washington St., Hagerstown, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Frank E. Brumback, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
22b. DATE THEREOF: 9/22/59
22c. NAME OF CEMETERY OR CREMATORY: Geo. Wash. Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 24 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10726

CERTIFICATE OF DEATH

10714
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 41 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 918 SALEM AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 918 SALEM AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH — Middle ALMIRA — Last HOFFER

4. DATE OF DEATH: Month SEPT. — Day 28 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/25/1881

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HANSON GRADY

14. MOTHER'S MAIDEN NAME: SUSAN HOLDERMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 214-09-7111

INFORMANT: MRS. ELISE LUSBAUGH — HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO
(b): Ca. of Breast — 5 YRS
DUE TO
(c):

170 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-26, 1959, to 9-28, 1959 that I last saw the deceased alive on 9-28, 1959, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John D. Turco M.D. — ADDRESS (Street, city or town, state): 302 W. Potomac St — DATE SIGNED: 9-29-59

PHYSICIAN'S NAME (Type): JOHN D. TURCO — Hagerstown Md.

22a. BURIAL, CREMATION REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/30/59
22c. NAME OF CEMETERY OR CREMATORY: ROSEDALE CEM.
22d. LOCATION (City town, or county) (State): MARTINSBURG W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Wormert — ADDRESS: Hagerstown Md

24a. REC'D BY REGISTRAR DATE: OCT 5 59

24b. REGISTRAR'S SIGNATURE: Wilbur J. Trump

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10727

CERTIFICATE OF DEATH

10715
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b: 55yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland
d. STREET ADDRESS: 44 Harmon Alley.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: W — Last: Hopewell

4. DATE OF DEATH: Month: Sept — Day: 19 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 11 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Junk yard

11. BIRTHPLACE (State or foreign country): Frederick, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Hopewell

14. MOTHER'S MAIDEN NAME: Unknew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.: 214-09-9526

17. INFORMANT: Mrs Derthy Gurlin — Address: 47 W. Bethel St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease with failure
I 50.0
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, generalized

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 20, 1959, to Sept. 19, 1959, that I last saw the deceased alive on Sept. 19, 1959, and that death occurred at 5:27P M, DST from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. T. Layman, M.D — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. Hagerstown Maryland — DATE SIGNED: 9/21/59

PHYSICIAN'S NAME (Type): William T. Layman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-22-1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR: SEP 25 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10716

10728

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland
c. LENGTH OF STAY IN 1b: 55yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 125 Blooms Alley

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland.
d STREET ADDRESS: 125 Blooms Alley
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virgie — Middle: Mae — Last: Johnsen

4. DATE OF DEATH: Month: 9 — Day: 23 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 25 1882

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11 BIRTHPLACE (State or foreign country): Leudon County, Va.

12 CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Lucas Hiram

14 MOTHER'S MAIDEN NAME: Mary Beem

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: William Johnsen 125 Blooms Alley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Colon
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6-12 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from Sept 1 1959 to Sept 23 1959, that I last saw the deceased alive on Sept 1 1959, and that death occurred at 4.30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D. — ADDRESS (Street, city or town, state): 159 W. Washington St Hagerstown Md — DATE SIGNED: 9/23/59

PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D. — 159 W. Washington St., Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-26-1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John R Watson Jr. Hagerstown Md

24a. REC'D BY REGISTRAR — DATE: SEP 29 '59

24b REGISTRAR'S SIGNATURE: Arthur L Keane

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10729

CERTIFICATE OF DEATH

Reg. Dist. No. 302

10717

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 33 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 24 Winter St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Hagerstown
d. STREET ADDRESS: 24 Winter St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHERINE Middle ELIZABETH Last KENDLE

4. DATE OF DEATH: Month September Day 29 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov 29 1879
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thadeous Mundey
14. MOTHER'S MAIDEN NAME: Rosana Bloomenour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Lester G Kendle Address: 353 Devonshire Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Senility & Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
(b): Arteriosclerosis. — DUE TO — Years
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 56 to 29 Sept, 19 59, that I last saw the deceased alive on 28 Sept, 19 59, and that death occurred at 2 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. W. Coffman M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 9/29/59
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/1/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: OCT 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Frush

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10765 — Reg. Dist. No. 10718

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock
c. LENGTH OF STAY IN 1b: I7 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hancock Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. — b. COUNTY: Morgan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Paw Paw
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Deneen — Last: Kifer
4. DATE OF DEATH: Month: Sept. — Day: 9, — Year: 1959

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: June 23, I885
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months 2 Days I6 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bldg. Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Kifer, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Kifer
14. MOTHER'S MAIDEN NAME: Amanda Ashkettle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Latoia Kifer, Address: Kifer Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.0
DUE TO (b): Arteria Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in bath tub
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: Dec 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Paw Paw — (County): — (State): W. Va

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dr W Dittoe M.D.
EXAMINER'S NAME (Type): Dr E W Dittoe Jr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/9/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/I3/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Darby Funeral Home — ADDRESS: Berkeley Springs W. Va.
24a. REC'D BY REGISTRAR — DATE: SEP 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Knode

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10766

CERTIFICATE OF DEATH

Reg. Dist. No. 10719

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: 64 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: REEDER NURSING HOME

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X APPLETOWN - RURAL
d. STREET ADDRESS: BOONSBORO MD. R.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORENCE Middle VIRGINIA Last KLINE

4. DATE OF DEATH: Month SEPT. Day 6 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH. 25. 1880
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months 5 Days 11
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): NR. MYERSVILLE FRED. CO. MD. U.S.A.
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JACOB SHANK
14. MOTHER'S MAIDEN NAME: ELLA ALEXANDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: ALTON B. KLINE Address: BOONSBORO MD. R.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
450.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 22 1959 to Sept. 6 1959 that I last saw the deceased alive on Sept. 4 1959, and that death occurred at 3 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. LeVan M.D. ADDRESS (Street, city or town, state): Boonsboro DATE SIGNED: 9/8/59

PHYSICIAN'S NAME (Type): G. W. LeVan

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT. 8 1959
22c NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John D. Coat ADDRESS: BOONSBORO MD.
24a. REC'D BY REGISTRAR DATE: SEP 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10720

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10730

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 05 Hagerstown
d. STREET ADDRESS: 114 E. Franklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MATTIE — Middle LAVINIA — Last KROUSE

4. DATE OF DEATH: Month September — Day 17 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 30, 1914

9. AGE (In years last birthday): 45 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weaver

10b. KIND OF BUSINESS OR INDUSTRY: Ribbon Factory

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Snyder

14. MOTHER'S MAIDEN NAME: Estella Gearhart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edwin W. Krouse — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Third Degree Burns of 90% of Body — INTERVAL BETWEEN ONSET AND DEATH: Instantly

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 416.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): lighting cigarette & caught fire from electric stove

20c. TIME OF INJURY: Hour 12 Noon — Month, Day, Year 9/16 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) HAGERSTOWN (County) WASH. (State) MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward M. Davis M.D

EXAMINER'S NAME (Type): Edward M. Davis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9/18/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/19/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) Hagerstown, (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home, R. Franklin Rouzer

ADDRESS: Hagerstown, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 21 '59

24b. REGISTRAR'S SIGNATURE: Carlton L. Reed

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 2/57

1

Item 18 Film 249 10-5-59 ams

10731

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10721

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY: Washington (MARYLAND)	2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown	c. LENGTH OF STAY IN 1b: 28 days
	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sharpsburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland Hospital	d. STREET ADDRESS: 225 W. Antietam Street
	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First / Middle / Last	4. DATE OF DEATH Month / Day / Year
Norman Harry Lapole	Sept. 29 1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White		April 28 1937	22 yrs.	5 / 0	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Never Worked	None	Chestnut Grove Md.	U. S. A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wilbur John Lapole	Ellen Iola Gross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
No	No	None	Mr. Wilbur Lapole	225 W. Antietam St. Sharpsburg Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Aspiration Pneumonia	8 hours
193.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	sarcomatosis general [illegible]	5 years
DUE TO (c)	Neurofibrosarcoma of humerus	8 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 31, 1959, to Sept. 29, 1959, that I last saw the deceased alive on Sept. 29, 1959, and that death occurred at 2:15 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor L. Ramos, M.D. — ADDRESS (Street, city or town, state): western md. State Hospital — DATE SIGNED: Sept 29/59

PHYSICIAN'S NAME (Type): VICTOR L. Ramos — Hagerstown, maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct. 3 1959	Mt. View Cemetery	Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 2 '59	24b. REGISTRAR'S SIGNATURE
[illegible]	[illegible]		Arthur J. Krause

1

10732 10722

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Myersville
d. STREET ADDRESS: Route # 2 Wolfsville
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: HARRY — Middle: JACKSON — Last: LEATHERMAN
4. DATE OF DEATH: Month: September — Day: 5 — Year: 1959

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: June 25, 1893
9. AGE (in years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cabinet maker
10b. KIND OF BUSINESS OR INDUSTRY: Morgans Lumber Mill
11. BIRTHPLACE (State or foreign country): Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Harlan Leatherman
14. MOTHER'S MAIDEN NAME: Amanda Frushour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-36-6968
17. INFORMANT: Mrs. Rae Leatherman — Address: Rt.# 2, Myersville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Perforation of Jejunum — INTERVAL BETWEEN ONSET AND DEATH: 14 days
910.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Intraabdominal Hemorrhage
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

2

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck in stomach by board from ripsaw
20c. TIME OF INJURY: Hour 330 p.m. — Month, Day, Year: 8-21 1959
20d. INJURY OCCURRED: While at work [X] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Factory
20f. (City or town) (County) (State): Wolfsville Frederick Md

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and find that death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: E W Ditto Jr. M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 9/5/59
EXAMINER'S NAME (Type): Dr E W Ditto Jr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept.8,1959
22c. NAME OF CEMETERY OR CREMATORY: St. Mark's Luth.
22d. LOCATION (City, town, or county) (State): Wolfsville,Fred.Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Paul F. Bittle — ADDRESS: Myersville, Md.
24a. REC'D BY REGISTRAR DATE: SEP 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10733

CERTIFICATE OF DEATH

10723

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 103 W. Franklin Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 103 W. Franklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ROY	EDWIN	LEWIS	September	12	19 59

5 SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
male	white		October 26, 1891	67 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Retired janitor	Drug Store	Hagerstown, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William H. Lewis	Clara A. Wolf

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
Yes W.W. I	214-09-4699	George W. Lewis	Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Edema	2 days
DUE TO (b)	Congestive heart failure	2 weeks
DUE TO (c)	Arteriosclerotic Cardiovascular Renal	Several years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 3/31/59 19____ to 9/12/59 19____, that I last saw the deceased alive on 9/2/59 19____, and that death occurred at 3 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard W. Wack, M.D. M.D. — ADDRESS (Street, city or town, state): 240 North Potomac St. Hagerstown, Md. — DATE SIGNED: 9/14/59

PHYSICIAN'S NAME (Type): Howard W. Wack, M.D. — Hagerstown, Md.

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	9/14/1959	Rose Hill Cemetery	Hagerstown,	Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Suter-Rouzer Funeral Home N. Franklin Rouzer	Hagerstown, Md.	SEP 15 '59	Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10734

CERTIFICATE OF DEATH

Reg. Dist. No. 10724

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Thurmont
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sadah — Middle: Raye — Last: Long

4. DATE OF DEATH: Month: Sept. — Day: 3 — Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 10, 1895
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. Hooker Lewis
14. MOTHER'S MAIDEN NAME: Laura V. Kelbaugh

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 180-22-3963
INFORMANT: A — Address: Roy A. Long, Thurmont, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: few minutes

237 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): Pulmonary embolism
DUE TO (c): During subocc. craniotomy for brain tumor

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/31, 1959, to 9/3, 1959, that I last saw the deceased alive on 9/3, 1959, and that death occurred at 12 9. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. F. Abdullah M.D. — ADDRESS (Street, city or town, state): 132 N. Potomac — DATE SIGNED: 9/3/59

PHYSICIAN'S NAME (Type): A. F. Abdullah — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-6-59
22c. NAME OF CEMETERY OR CREMATORY: Creagerstown Cem.,
22d LOCATION (City, town, or county) (State): Creagerstown, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Creager — ADDRESS: Thurmont, Md.
24a. REC'D BY REGISTRAR — DATE: SEP 8 '59
24b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10735

CERTIFICATE OF DEATH

10725

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1½ months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 652 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle SYLVESTER Last McBRIDE

4. DATE OF DEATH: Month SEPTEMBER Day 18 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Oct. 16 1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer at Pangborn
10b. KIND OF BUSINESS OR INDUSTRY: Manf. of Dust Collectors
11. BIRTHPLACE (State or foreign country): Ronney W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William Newton Mc Bride
14. MOTHER'S MAIDEN NAME: Elsie Kidwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 232-26-6152
INFORMANT: Mrs. Wilbur Carbaugh Address: Maugansville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Edema and Congestion	3 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)	Confluent Lobular pneumonia	5 days
DUE TO (c)	Carcinoma Right Lung, Regional Metastasis	3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary Atherosclerosis, Severe
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 10, 1959, to Sept. 18, 1959, that I last saw the deceased alive on Sept 18, 1959, and that death occurred at 7:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Evaristo R. Lardizabal M.D. ADDRESS (Street, city or town, state): 1500 Pennsylvania Ave. DATE SIGNED: 9-18-59

PHYSICIAN'S NAME (Type): Evaristo R. Lardizabal Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 22-59
22c. NAME OF CEMETERY OR CREMATORY: Church of God Cemetery
22d. LOCATION (City town or county) (State): Blairs Valley, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Zeigler ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: SEP 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10726

10736

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 14 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2316 Jefferson Blvd.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
f. STREET ADDRESS: 2316 Jefferson Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First P. Middle WALTER Last MC CLAIN

4. DATE OF DEATH: Month September Day 24 Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 9, 1895

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plant Guard

10b. KIND OF BUSINESS OR INDUSTRY: Aircraft Factory

11. BIRTHPLACE (State or foreign country): Edgemont, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter M. Mc Clain

14. MOTHER'S MAIDEN NAME: Nettie G. Dowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-09-1893

17. INFORMANT Address: Mrs. Margaret V. Mc Clain Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Hemorrhage
DUE TO
(b): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ o. m. p. m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1, 1958 to Sept. 24, 1959 that I last saw the deceased alive on Sept. 22, 1959 and that death occurred at 2 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

ACTUAL SIGNATURE: D. J. Boyer M.D. DATE SIGNED: 9-24-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/26/1959
22c. NAME OF CEMETERY OR CREMATORY: Smithsburg, Cemetery
22d. LOCATION (City, town, or county) (State): Smithsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R. Franklin Rouzer
ADDRESS: Suter-Rouzer Funeral Home Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: SEP 28 59
24b. REGISTRAR'S SIGNATURE: Curtis A. Pelham

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10737 — 10727 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md.
c. LENGTH OF STAY IN 1b: 7 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prospect Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md.
d. STREET ADDRESS: Prospect Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joe — Middle: Marie — Last: Mc Pherson
4. DATE OF DEATH: Month: Sept. — Day: 9 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 26 1959
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 7 Days: 13 — IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Hagerstown Md.
12. CITIZEN OF WHAT COUNTRY?: U. S. A
13. FATHER'S NAME: Robert Mc Pherson
14. MOTHER'S MAIDEN NAME: Trixie Berneda Stevens
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Raymond Staley — Address: Pinesburg Williamsport Md RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ?
DUE TO (b): Suffocation by foreign body in mouth & throat — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Baby found cattle in mouth
20c. TIME OF INJURY: Hour: 8 p. m. — Month, Day, Year: 9-8 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Hagerstown Wash Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: A. W. Leitch Jr. M.D.
EXAMINER'S NAME (Type): A. W. Leitch Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/9/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 11-59
22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Alvin Britton, Williamsport Md
24a. REC'D BY REGISTRAR DATE: SEP 10 '59
24b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the ... date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and ... to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10767 | 10728 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 71 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown
d. STREET ADDRESS: Route 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George Middle: Nelson Last: Messner
4. DATE OF DEATH: Month: 9 Day: 20 Year: 1959
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 27, 1888
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.
11. BIRTHPLACE (State or foreign country): Thurmont, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George W. Messner
14. MOTHER'S MAIDEN NAME: Sarah Rodgers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-14-7304A
17. INFORMANT: Jesse E. Messner Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion (Rt.)
825X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): Fracture 4th. & 5th. Ribs Rt.

INTERVAL BETWEEN ONSET AND DEATH: 22 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident
20c. TIME OF INJURY Hour: 7 p. m. Month, Day, Year: 9-19- 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): S. Potomac St. Ext.
20f (City or town): Hagerstown (County): Washington (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. W. Ditto M.D.
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9-21-59

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 9-23-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Brethren
22d. LOCATION (City, town, or county): Luray (State): Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Fred W. Kraiss Hagerstown, Md.
24a. RECD BY REGISTRAR DATE: SEP 25 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10768

CERTIFICATE OF DEATH

10729
Reg. Dist. No.

1

Dr. Max Byrkit
28 W. Potomac St
Williamsport

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIRPLAY - RURAL
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAIRPLAY M.D. R.1

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FAIRPLAY - RURAL
d. STREET ADDRESS: FAIRPLAY MD. R. 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): GEORGE W. MIDDLEKAUFF
4. DATE OF DEATH: SEPT - 14 - 1959

5 SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: MAY-15-1881
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months 3 Days 29
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM
11. BIRTHPLACE (State or foreign country): FAIRPLAY WASH. Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: AARON C. MIDDLEKAUFF
14. MOTHER'S MAIDEN NAME: LAURA EAKLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 219-36-2503
17. INFORMANT Address: MRS. ALBERT V. FORD FAIRPLAY MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Myocadial insufficiency — 5 yrs
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9-10, 1959, to 9-14, 1959, that I last saw the deceased alive on 9-14, 1959, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M.E. Byrkit M.D
ADDRESS (Street, city or town, state): 28 W. Potomac St
DATE SIGNED: 9-15-59

PHYSICIAN'S NAME (Type): Max E. Byrkit, M.D. — Williamsport, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT. 17 1959
22c. NAME OF CEMETERY OR CREMATORY: BAKERSVILLE CEMETERY
22d. LOCATION (City, town, or county) (State): BAKERSVILLE WASH. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John K. Crist
ADDRESS: BOONSBORO MD.
24a. REC'D BY REGISTRAR DATE: SEP 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10738

CERTIFICATE OF DEATH

10730

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 14 YEARS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 249 MILL STREET, HAGER PARK

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 249 MILL ST. HAGER PARK
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BESSIE Middle: AMELIA Last: MILLER

4. DATE OF DEATH: Month: SEPTEMBER Day: 19 Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 28 1886

9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months: 5 Days: 21 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): TILGHMANTON WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: SAMUEL B. HARTLE

14. MOTHER'S MAIDEN NAME: ELLEN SHOWE

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

INFORMANT: IVAN C. MILLER Address: 249 MILL ST. HAGERSTOWN MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO (b): Hypertensive A.S. Heart Disease — 10 yrs
DUE TO (c): Diabetes Mellitus — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. p. m. Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1958, 19___, to 9/19/59, 19___, that I last saw the deceased alive on 6.00 P.M. 9/19/59 and that death occurred at 6.02 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Young M.D. ADDRESS (Street, city or town, state): 146 N. Potomac DATE SIGNED

PHYSICIAN'S NAME (Type): EARL YOUNG M.D. Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT 22 1959

22c. NAME OF CEMETERY OR CREMATORY: MANOR CEMETERY

22d. LOCATION (City, town, or county) (State): NR. TILGHMANTON WASH. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John D. Bast ADDRESS: BOONSBORO MD

24a. REC'D BY REGISTRAR DATE: SEP 25 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10739

CERTIFICATE OF DEATH

Reg. Dist. No. 10731

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 8 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 328 N.Mulberry St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARCUS — Middle ROBINSON — Last MILLER

4. DATE OF DEATH: Month Sept. — Day 11 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 16,1920

9. AGE (In years last birthday): 39 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Aircraft

11. BIRTHPLACE (State or foreign country): Cumberland,Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Chester Martin Miller

14. MOTHER'S MAIDEN NAME: Lula Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service)): No

16. SOCIAL SECURITY NO.: 214-05-4525

INFORMANT — Address: Mrs.M.R.Miller 328 N.Mulberry St.Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Rheumatic Heart Disease. — Years.
DUE TO (c):

416X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 30, 1959 to Sept.11, 1959 that I last saw the deceased alive on Sept. 10, 1959, and that death occurred at 6:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A.Bell M.D. — ADDRESS (Street, city or town, state): 119 N. Potomac Street, — DATE SIGNED: 9-12-59

PHYSICIAN'S NAME (Type): R.A.Bell, M.D. — Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/14/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md.

24a. REC'D BY REGISTRAR DATE: SEP 15 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Wm. G. Host

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10732

CERTIFICATE OF DEATH

10740 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick-Rural RD#6
d. STREET ADDRESS: Bartonsville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gerald — Middle: E. — Last: Moberly
4. DATE OF DEATH: Month: September — Day: 11, — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 10, 1909
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George H. B. Moberly
14. MOTHER'S MAIDEN NAME: Viola Roelke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-10-5271
17. INFORMANT — Address: Mrs. Helen M. Moberly- Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory and Circulatory failure — INTERVAL BETWEEN ONSET AND DEATH
332 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Massive infarct (Rt) Cerebral hemisphere — 2 days.
DUE TO
(c): Atherosclerosis and cerebral thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/9, 1959, to 9/11, 1959, that I last saw the deceased alive on 9/11, 1959, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A-F. Abdullah, M.D. — ADDRESS (Street, city or town, state): 132 N. Potomac — DATE SIGNED
PHYSICIAN'S NAME (Type): A-F. Abdullah — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 14, 1959
22c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Frederick, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: M. R. Etchison & Son, Frederick, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 15 '59
24b. REGISTRAR'S SIGNATURE: Curtis L. Frame

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10741

CERTIFICATE OF DEATH

Reg. Dist. No 11909

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 15 MINUTES
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOONSBORO
d. STREET ADDRESS: NORTH MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle AILEEN Last MULLENDORE

4. DATE OF DEATH: Month SEPTEMBER Day 29 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 20 1893

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months 5 Days 9 IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BOONSBORO WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: J. CALVIN FLOOK

14. MOTHER'S MAIDEN NAME: OLIVE BOWMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-12-1414

INFORMANT: HARRY W. MULLENDORE Address: BOONSBORO MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH: 30 Days.

200.2

DUE TO (b): MALIGNANT LYMPHOMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1959, to September 29 1959, that I last saw the deceased alive on 9-29-1959, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. Secondari M.D. ADDRESS (Street, city or town, state): BOONSBORO MARYLAND DATE SIGNED:

PHYSICIAN'S NAME (Type): SECONDARI JOSEPH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Oct 2 1959

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Bard. ADDRESS: BOONSBORO MD

24a. REC'D BY REGISTRAR DATE: OCT 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10733

CERTIFICATE OF DEATH

10742 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
d. STREET ADDRESS: ST. PAUL ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle D Last MULLOOLY

4. DATE OF DEATH: Month SEPTEMBER Day 22 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL-19-1908

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months 5 Days 3
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PACKAGE LIQUOR STORE OPERATOR—OWN STORE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MT. SAVAGE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ARTHUR MULLOOLY

14. MOTHER'S MAIDEN NAME: CATHERINE GRAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W. 2.

16. SOCIAL SECURITY NO.: 214-07-1931

INFORMANT: MRS. DELCIE MULLOOLY Address: BOONSBORO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): HEPATIC COMA — 581.0

DUE TO (b): LIVER CIRRHOSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 10 Days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9-12-, 1959, to 9-22-, 1959, that I last saw the deceased alive on 9-21-, 1959, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H Secondari M.D. ADDRESS (Street, city or town, state): BOONSBORO MD DATE SIGNED: 9-23-59

PHYSICIAN'S NAME (Type): JOSEPH SECONDARI MD BOONSBORO M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT. 26. 1959

22c. NAME OF CEMETERY OR CREMATORY: CREST LAWN CEMETERY

22d LOCATION (City, town, or county) (State): LAVALE ALLEGHENY CO. MD.

23 FUNERAL DIRECTOR'S SIGNATURE: John N. Boast ADDRESS: BOONSBORO MD.

24a REC'D BY REGISTRAR DATE: SEP 25 '59

24b. REGISTRAR'S SIGNATURE: Clifton A. Kinna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death)

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10734

CERTIFICATE OF DEATH

10743

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 months 18d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 516 Frederick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle SUSAN Last PALMER

4. DATE OF DEATH: Month September Day 17 Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 8, 1901

9. AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): near Downsville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Dorsey

14. MOTHER'S MAIDEN NAME: Susan Danner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: W. Herman Palmer Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary infarction & pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1-2 wks.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Marked generalized atherosclerosis — 3-4 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension, Cardiac failure, Liver Congestion

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 30 JUNE, 1959, to 17 SEPT., 19 59, that I last saw the deceased alive on 16 SEPTEMBER, 19 59, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 135 POTOMAC AVENUE
DATE SIGNED: 18 SEPT. 1959

PHYSICIAN'S NAME (Type): RICHARD T. BINFORD, M. D.
HAGERSTOWN, MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/19/1959
22c. NAME OF CEMETERY OR CREMATORY: River View Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
A. Franklin Rouzer
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: SEP 21 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be relieved by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10744

CERTIFICATE OF DEATH

10735 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 46 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION 344 West Side Ave.

2. USUAL RESIDENCE (Where deceased lived If institution. Res dence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 344 West Side Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Lillian Middle Virginia Last Pittenger
4. DATE OF DEATH Month Sept Day 16 Year 19 59

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 26, 1890
9. AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Franklin Co. Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Daniel M. Whetstone
14. MOTHER'S MAIDEN NAME Lucy Irwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ----- (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ----
INFORMANT Mrs W. Lyman Ott Address Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastasis — INTERVAL BETWEEN ONSET AND DEATH 2 wks.
DUE TO (b) Lymphosarcoma — 7 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr. 19 59 to 16 Sept 19 59 that I last saw the deceased alive on 15 Sept 19 59, and that death occurred at 8 A M, from the causes and on the date stated above

ACTUAL SIGNATURE Jos. Wilson M.D.
ADDRESS (Street, city or town, state) 135 N. Potomac St.
DATE SIGNED 9/16/59
PHYSICIAN'S NAME (Type) J. D. Wilson Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-18-59
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State) Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE SEP 21 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 13

10745

CERTIFICATE OF DEATH

Reg. Dist. No. 10736

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 344 Sherwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Ann — Middle Straight — Last Poe

4. DATE OF DEATH: Month September — Day 27 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 3, 1902
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Social Security
11. BIRTHPLACE (State or foreign country): Grags Falls, W.Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willie S. Straight
14. MOTHER'S MAIDEN NAME: Arizona Haught

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
INFORMANT: G. Edward Poe — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Septic Coma
DUE TO (b): Metastatic Ca
DUE TO (c): Carcinoma of Lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: (a) 1 wks; (b) 2-3 months; (c) 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/1/59, 19__, to 9/27/59, 19__, that I last saw the deceased alive on 9/27/59, 19__, and that death occurred at 12:45A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 136 N. Potomac St
DATE SIGNED: 9/27/59
PHYSICIAN'S NAME (Type): Howard N. Weeks — Hagerstown

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-30-59
22c. NAME OF CEMETERY OR CREMATORY: Luthern Cemetery
22d LOCATION (City, town, or county) (State): Leitersburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: OCT 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10746

CERTIFICATE OF DEATH

10737

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 72 East Ave

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 72 East Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LeROY — Middle NMN — Last POLSGROVE

4. DATE OF DEATH: Month September — Day 8 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 15 1886

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Pa. St Thomas Franklin Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jesse H. Polsgrove

14. MOTHER'S MAIDEN NAME: Mary C Graham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes — W.W.# 1

16. SOCIAL SECURITY NO.: 214-09-7633

17. INFORMANT — Address: Mrs Daisy M. Polsgrove 72 East Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Large Bowel. — INTERVAL BETWEEN ONSET AND DEATH: 10 months

153.8

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Colostomy performed November 1958.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 4, 1958, to Sept. 8, 1959, that I last saw the deceased alive on Sept. 8, 1959, and that death occurred at 6:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A. Bell M.D.

ADDRESS (Street, city or town, state): 119 North Potomac St., 9-9-59

DATE SIGNED

PHYSICIAN'S NAME (Type): R.A.Bell, M.D. — Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/11/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md

24a. REC'D BY REGISTRAR DATE: SEP 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kimmel

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10747

CERTIFICATE OF DEATH

Reg. Dist. No. 10738

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Md. b. COUNTY: Wash.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c LENGTH OF STAY IN 1b: 54 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 31 Randolph Ave.

d. STREET ADDRESS: 31 Randolph Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Lydia — Middle Miner — Last Rudisill

4. DATE OF DEATH: Month Sept. Day 1 Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 7, 1882

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): housewife

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Smithsburg, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Miner

14. MOTHER'S MAIDEN NAME: Sarah Bowman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: George A. Rudisill, Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 2 minutes

420.0

DUE TO (b): Arteriosclerotic Heart Disease — 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis — yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from Aug 29, 1959 to Sept. 1, 1959 that I last saw the deceased alive on Sept. 1, 1959, and that death occurred at 3:10 A M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: Lloyd A. Hoffman M.D — 214 N. Potomac St. — 9/2/59

PHYSICIAN'S NAME (Type): Lloyd A. HOFFman — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 9-3-59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: SEP 4 '59

24b. REGISTRAR'S SIGNATURE: Clifton L Frank

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10748 — 10739 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b: 23 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 518 W. Howard St

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland — b COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 518 W. Howard St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Carrie — Middle Summer — Last Seibert
4. DATE OF DEATH: Month September — Day 28 — Year 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 28, 1873
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Shady Grove Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elias Summer
14. MOTHER'S MAIDEN NAME: Elmira Fouke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT — Address: J. Clarke Seibert, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardio-Vascular Disease
DUE TO (c) ____
INTERVAL BETWEEN ONSET AND DEATH: 20

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour ____ a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) J. Ew Dittoe M D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 9/29/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-1-59
22c. NAME OF CEMETERY OR CREMATORY: St. Paul's Ref. Church
22d. LOCATION (City, town, or county) (State): Western Pike, Hag., Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE OCT 5 '59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10740
Reg. Dist. No.

10769

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D.5 Hagerstown

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Waynesboro
d. STREET ADDRESS: R.D.3 Waynesboro
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: Lester — Last: Shank
4. DATE OF DEATH: Month: Sept. — Day: 5 — Year: 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 25, 1896
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Waynesboro, Pa. R.D.3
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Simon Shank
14. MOTHER'S MAIDEN NAME: Sadie Benchoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 173-03-1285
17. INFORMANT — Address: Fred L. Shank Smithsburg, Md. R.D.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a):
DUE TO
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Fracture Skull — instant
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto failed to make curve on highway hitting Pole
20c. TIME OF INJURY: Hour 8 a.m. p.m. — Month, Day, Year: 9-5 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Marsh Pike
20f. (City or town) Hagerstown (County) Wash. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: J W Dutt Jr M.D.
EXAMINER'S NAME (Type): J W DUTT Jr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/6/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/8/1959
22c. NAME OF CEMETERY OR CREMATORY: Green Hill
22d. LOCATION (City, town, or county) (State): Waynesboro, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y Kline
ADDRESS: Waynesboro, Pa.
24a. REC'D BY REGISTRAR — DATE: SEP 9 '59
24b. REGISTRAR'S SIGNATURE: Collins & Kline

TO IDENTITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10749

CERTIFICATE OF DEATH

Reg. Dist. No. 10741

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md.
d. STREET ADDRESS: 413 Ross St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Silas — Middle: Thomas — Last: Shank

4. DATE OF DEATH: Month: Sept. — Day: 12 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 10 1888

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months: 1 Days: 1 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret'd Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Silk Mill

11. BIRTHPLACE (State or foreign country): Luray Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Thomas Shank

14. MOTHER'S MAIDEN NAME: Annabelle Bateman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 165 10 9851

17. INFORMANT: Mrs. Helen Shank — Address: 413 Ross St. Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral apoplexy
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

334 X

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m, 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/11/59, 19, to 9/12/59, 19, that I last saw the deceased alive on 9/14/59, 19, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F. Young, M.D. — ADDRESS (Street, city or town, state): Williamsport, Md. — DATE SIGNED: 9/14/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 16-59

22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

22d. LOCATION (City, town, or county) (State): Williamsport Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR DATE: SEP 15 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10750 — Reg. Dist. No. 10742

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Hagerstown
d. STREET ADDRESS: 604 Summit Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle FAYMAN — Last SHILLING Sr.
4. DATE OF DEATH: Month Sept. — Day 9 — Year 1959

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: August 10,1905 — 9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheetmetal Supvr. — 10b. KIND OF BUSINESS OR INDUSTRY: Pangborn Corp.(Mfg) — 11. BIRTHPLACE (State or foreign country): Chewsville,Md. — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph H.Shilling — 14. MOTHER'S MAIDEN NAME: Ida Grey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: 214-09-5961 — INFORMANT: Mrs.J.F.Shilling — Address: 604 Summit Ave.Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Dilated polycystic kidneys, ark. — INTERVAL BETWEEN ONSET AND DEATH: (Congenital)
757.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): uremia — 1wk.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): multiple cysts of liver and pancreas. — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 21, 1958, to Sept 4, 1959, that I last saw the deceased alive on Sept 9, 1959, and that death occurred at 1 55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C. Crisp M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): Joseph C.Crisp — 115 King St.Hagerstown,Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/12/59 — 22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery — 22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md. — 24a. REC'D BY REGISTRAR DATE SEP 14 '59 — 24b. REGISTRAR'S SIGNATURE: Curtis L Kinna

Wm. C. Horst Mrs

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

Item 20 Film 249 10-5-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10751

Reg Dist. No. 10743

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MAPLEVILLE
d. STREET ADDRESS: MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle A. Last SHOOP

4. DATE OF DEATH: Month SEPTEMBER Day 18 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 26 - 1870

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months 2 Days 22
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED BLACK SMITH - OWN SHOP

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MAPLEVILLE WASH. Co. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JONATHAN SHOOP

14. MOTHER'S MAIDEN NAME: LYDIA MYERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

INFORMANT Address: MRS. ELMER REEDER MAPLEVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO (b): Fracture of right hip
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9047

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Undressing to go to bed, lost balance & fell

20c. TIME OF INJURY: Hour 8 p. m. Month 9 Day 11 Year 59

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Conv. Home

20f. (City or town): Hagerstown (County): Wash (State): Md.

21. I certify that I attended the deceased from Sept 12, 19 59, to Sept 15, 19 59, that I last saw the deceased alive on Sept 14, 19 59, and that death occurred at 11 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. Leiter M.D. ADDRESS (Street, city or town, state): Boonsboro Md. DATE SIGNED: 9/21/59

PHYSICIAN'S NAME (Type): G. W. Leiter Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT. 21-1959

22c. NAME OF CEMETERY OR CREMATORY: FAHRNEYS CEMETERY

22d. LOCATION (City, town, or county) (State): NR. MAPLEVILLE WASH. Co MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bard ADDRESS: BOONSBORO MD.

24a. REC'D BY REGISTRAR DATE: SEP 25 '59

24b. REGISTRAR'S SIGNATURE: Orline S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10770

CERTIFICATE OF DEATH

Reg. Dist. No. 10744

1 PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEWSVILLE RURAL
c. LENGTH OF STAY IN 1b 34 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHEWSVILLE RURAL
d. STREET ADDRESS [illegible]
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First RUTH Middle E Last SHOOP

4. DATE OF DEATH Month SEPTEMBER Day 19 Year 1959

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH JANUARY 2 - 1895
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME
11. BIRTHPLACE (State or foreign country) MARLEVILLE WASH. CO. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JONAS MOSER
14. MOTHER'S MAIDEN NAME MINNIE WEAVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 220-34-6786
INFORMANT Address EDGAR R. SHOOP CHEWSVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia / Bronchial / Bronchitis — INTERVAL BETWEEN ONSET AND DEATH 30 min
DUE TO (b) Diabetes Mellitus / Arterio Sclerotic Heart — 10 yrs / 10 yrs
DUE TO (c) Arterio Sclerosis (generalized) — 11 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 10, 19 59, to Sept 19, 19 59, that I last saw the deceased alive on Sept 19, 19 59, and that death occurred at 10:20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE G. G. K Ohler M.D. ADDRESS (Street, city or town, state) Smithsburg Md DATE SIGNED 9/19/59

PHYSICIAN'S NAME (Type) G. A. KOHLER

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF SEPT. 23. 1959
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY
22d. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE John H. Bast ADDRESS BOONSBORO MD.
24a. REC'D BY REGISTRAR DATE SEP 25 '59
24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10752 **CERTIFICATE OF DEATH** Reg. Dist. No. 10745

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural (Clearspring Md RFD #1)
d STREET ADDRESS Clearpsring Md RFD #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Bertha Middle May Last Shupp
4. DATE OF DEATH Month Sept. Day 7 Year 19 59
5 SEX Female
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Feb. 11 1889
9. AGE (In years last birthday) 70 yrs.
IF UNDER 1 YEAR Months 6 Days 26 IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME William Staley
14. MOTHER'S MAIDEN NAME Eliza Bloom
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Andrew S. Shupp Clearspring Md RFD #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA, RETROPERITONEAL — INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
200.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE
19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC. 5, 19 58, to SEPT 7, 19 59, that I last saw the deceased alive an SEPT 6, 19 59, and that death occurred at 12.30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Archie Robert Cohen M.D. ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D. CLEAR SPRING, MARYLAND SEPT. 8, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept. 10-59
22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery
22d. LOCATION (City, town, or county) (State) Near Clearspring Md.

23. FUNERAL DIRECTOR'S SIGNATURE Albert L Kiefaber ADDRESS Williamsport, Md
24a. REC'D BY REGISTRAR DATE SEP 9 '59
24b. REGISTRAR'S SIGNATURE Arthur S Kreps

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10746

CERTIFICATE OF DEATH

10771 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL NR. CLEAR SPRING
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAIRVIEW ROAD RESIDENCE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CLEAR SPRING, MD.
d. STREET ADDRESS: FAIRVIEW ROAD
e. IS RESIDENCE ON A FARM? YES [#] NO [ ]

3. NAME OF DECEASED (Type or print): First MARY Middle MARTHA Last SHUPP

4. DATE OF DEATH: Month SEPT. Day 25 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED [#] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: APRIL 25, 1890

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months 5 Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME DUTIES

11. BIRTHPLACE (State or foreign country): FOUR LOCKS, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL H. FERNSNER

14. MOTHER'S MAIDEN NAME: MARY ELIZA BREWER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

INFORMANT: ALVEY J. SHUPP Address: ROUTE 1, CLEAR SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion with myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

420.0

DUE TO (b) Arteriosclerotic heart disease — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 25, 19 59, to September 25 19 59, that I last saw the deceased ~~alive~~ dead Sept. 25, 19 59, and that death occurred at 9:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S NAME (Type): Archie Robert Cohen, M.D. — Clear Spring, Maryland — September 27, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT. 28, 1959

22c. NAME OF CEMETERY OR CREMATORY: ST. PAULS CEM.

22d. LOCATION (City, town, or county) (State): WASHINGTON MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Clark ADDRESS: Clear Spring, Md.

24a. REC'D BY REGISTRAR DATE: SEP 29 '59

24b. REGISTRAR'S SIGNATURE: Arthur A. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10747

CERTIFICATE OF DEATH

10753 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d STREET ADDRESS 222 South Prospect Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clifford Wade Middle Last Simmons

4. DATE OF DEATH: Month September Day 24 Year 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 23, 1909
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Swope Agusta Co. Va.
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harry A. Simmons
14. MOTHER'S MAIDEN NAME: Elizabeth Whisman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 224-07-9313
17. INFORMANT Mrs. Margie Simmons Address 222 South Prospect St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hours.
DUE TO (b) Coronary atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Atelectasis of right lower lobe due to chronic infection
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Coronary cardiac
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9-19 19 59 to 9-24 19 59 that I last saw the deceased alive on 9-24 19 59, and that death occurred at 8:40 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE John D. Turco M.D.

PHYSICIAN'S NAME (Type) JOHN D. TURCO 302 N. POTOMAC ST HAGERSTOWN MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-28-59
22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
22d. LOCATION (City, town, or county) (State): Churchville Augusta Co. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE OCT 2 '59
24b REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10754

CERTIFICATE OF DEATH

10748 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamson
d. STREET ADDRESS: Williamson
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nell — Middle: Williamson — Last: Snider

4. DATE OF DEATH: Month: September — Day: 29 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 11, 1885

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (State or foreign country): Franklin Co Penna

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William T. Williamson

14. MOTHER'S MAIDEN NAME: Ella Easton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Jas. B. C. Snider, Williamsport

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute bacterial endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 days ?
DUE TO (b): Chronic Nephritis & Acute Pneumonia — Uncertain
DUE TO (c): Fall Unattended

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 9/26, 1959, to 9-29, 1959, that I last saw the deceased alive on 9/29, 1959, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H Hornbaker M.D. — ADDRESS (Street, city or town, state): 154 W. Washington St., — DATE SIGNED: 9:30:59

PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D. — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/3/1959

22c. NAME OF CEMETERY OR CREMATORY: White Church Cemetery

22d. LOCATION (City, town, or county) (State): Franklin Co Penna

23. FUNERAL DIRECTOR'S SIGNATURE: Harold A. Zimmerman — ADDRESS: Greencastle Pa

24a. REC'D BY REGISTRAR DATE: OCT 5 '59

24b. REGISTRAR'S SIGNATURE: Clifford L Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10772

CERTIFICATE OF DEATH

Reg. Dist. No. 10749

1 PLACE OF DEATH
a. COUNTY Washington MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chewsville
c. LENGTH OF STAY IN 1b 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chewsville
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Emma C. Strite Snyder
4. DATE OF DEATH Month Day Year: September 26 1959

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 15, 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Leitersburg Md.
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Strite
14. MOTHER'S MAIDEN NAME: Catherine Maun

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 203-10-1320
INFORMANT Address: I. Frank Snyder Chewsville Box 61

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 24 hours
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Disease — years.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1959, to 26 Sept, 1959, that I last saw the deceased alive on 25 Sept, 1959, and that death occurred at 6:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE J. D. Wilson M.D.
ADDRESS (Street, city or town, state) 135 N. Potomac St.
DATE SIGNED 9/28/59
PHYSICIAN'S NAME (Type) J. D. Wilson Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-29-59
22c NAME OF CEMETERY OR CREMATORY: Grenn Hill Cemetery
22d. LOCATION (City, town, or county) (State): Waynesboro Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son Smithsburg Md.
24a. REC'D BY REGISTRAR DATE: OCT 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10773

10750
302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg R # 2
c. LENGTH OF STAY IN 1b: 7 Yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Itnyre Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg R # 2
d. STREET ADDRESS: Itnyre Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
GEORGE	OSWALD	SOWERS	September	4	1959 19

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
Male	White		Sept 23 1894	64 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Auto	White Hall Wash Co Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Sowers	Ida Bachtell

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
No	------	214-09-8634	Mrs Alice J. Lyon Smithsburg Md R # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Carcinomatosis secondary to — INTERVAL BETWEEN ONSET AND DEATH: 5 mos.

DUE TO: Bronchogenic Carcinoma.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 12, 19 59 to Sept. 4, 19 59 that I last saw the deceased alive on August 29, 19 59, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A.Bell M.D. — ADDRESS (Street, city or town, state): 119 North Potomac St. — DATE SIGNED: 9-5-59

PHYSICIAN'S NAME (Type): R.A.Bell, M.D. — Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)
Burial	9/6/59	Grind Stone Hill Cem.	near Chambersburg Penna

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md.	SEP 8 '59	Clifton L. Kreps

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10755

CERTIFICATE OF DEATH

10751

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1202 Hamilton Blvd

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Hagerstown
d. STREET ADDRESS: 1202 Hamilton Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JEANETTE Middle HELLER Last SOWERS

4. DATE OF DEATH: Month September Day 8 Year 1959

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Dec 23 1863
9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (State or foreign country): Md. Clearspring Wash Co
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eli Heller
14. MOTHER'S MAIDEN NAME: Mary Kreps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT Address: Mrs Aline Sowers 1202 Hamilton Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation — Interval between onset and death: minutes

DUE TO (b) Arteriosclerotic Heart Disease — Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized arteriosclerosis with cerebral vascular accident — Indefinite

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cataract

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1952 to September 1959 that I last saw the deceased alive on September 7 1959, and that death occurred at 5:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert F. Keadle M.D. — ADDRESS (Street, city or town, state): 318 N. Potomac St. — DATE SIGNED: 9-9-59

PHYSICIAN'S NAME (Type): Robert F. Keadle, M. D. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/10/59
22c. NAME OF CEMETERY OR CREMATORY: St Pauls Cemetery
22d. LOCATION (City, town, or county) (State): near Clearspring Wash Co Md

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: SEP 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10774 — Reg. Dist. No. — 11928

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): APPLETOWN - RURAL
c. LENGTH OF STAY IN 1b: 8 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BOONSBORO MD. R12

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X APPLETOWN RURAL
d. STREET ADDRESS: BOONSBORO MD. R12
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle F. — Last STOUFFER
4. DATE OF DEATH: Month SEPTEMBER — Day 27 — Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE-21-1901
9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months 3 — Days 6 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: MEAT MARKET
11. BIRTHPLACE (State or foreign country): MADLEVILLE WASH. CO. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: LUCURGUS STOUFFER
14. MOTHER'S MAIDEN NAME: ROSA BETTS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: MRS. LEILA STOUFFER — Address: BOONSBORO MD. R2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 422.1 — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chr. Myocarditis — 5 yrs
DUE TO (c): Arterio Sclerosis Severe

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: A. E. Dittoe M.D.
EXAMINER'S NAME (Type): A. E. DITTOE
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/28/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT. 30. 1959
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast — ADDRESS: BOONSBORO MD.
24a. REC'D BY REGISTRAR — DATE: OCT 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary please execute the [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

DR. DITTO X

VS A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10756

CERTIFICATE OF DEATH

10752
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c LENGTH OF STAY IN 1b: Life
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 221 Frederick St

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 221 Frederick St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thelma — Middle: Mildred — Last: Stouffer

4. DATE OF DEATH: Month: Sept. — Day: 12 — Year: 19 59

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 3, 1904
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hagerstown Md
12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Willoam H. Bowers
14. MOTHER'S MAIDEN NAME: Ida May Andrews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ---
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ---
INFORMANT: J. Fred Stouffer — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes

422.1

DUE TO (b): Arteriosclerotic myocarditis — Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hepatomegaly, cause undetermined but likely due to (2) above

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour, a.m. p.m.
20d INJURY OCCURRED White at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from on day and after death September 12, 1959 that I last saw the deceased alive on 5 to 6 years ago, 19 , and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert F. Keadle M.D.
ADDRESS (Street, city or town, state): 318 N. Potomac St. Hagerstown Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Robert F. Keadle

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 9-15-59
22c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: SEP 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kinna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10757

CERTIFICATE OF DEATH

10753 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 45 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1822 Gilbert Ave.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1822 Gilbert Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLIOT — Middle: HAMMOCK — Last: TURNER SR.

4. DATE OF DEATH: Month: Sept. — Day: 4 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb.7,1898

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ma chinist

10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.

11 BIRTHPLACE (State or foreign country): Shepherdstown,W.Va.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph D.Turner

14. MOTHER'S MAIDEN NAME: Emma C.Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-10-4683

INFORMANT: Elliot H.Turner Jr. 1822 Gilbert Ave. — Address: Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma L
DUE TO
(b): general metastasis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 8 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Mar 9, 1959 to Sept 4, 1959, that I last saw the deceased alive on Aug 27, 1959, and that death occurred at 8:45 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W Ditto III M.D. — ADDRESS (Street, city or town, state): 217 W. Washington Street — DATE SIGNED: 9-5-59

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M.D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 9/7/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d LOCATION (City town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md.

24a. REC'D BY REGISTRAR DATE SEP 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Wm. C. Hoxt c-Pres.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10758

CERTIFICATE OF DEATH

10754

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN.
c. LENGTH OF STAY IN 1b 1 MO 13 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MD STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21 4
d. STREET ADDRESS 1450 S CHARLES ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last WENDEL
4. DATE OF DEATH Month SEPT. Day 26 Year 1959

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH AUG 11 1897
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER HELPER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME PETERS WENDEL
14. MOTHER'S MAIDEN NAME ELIZABETH UNK

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 220-14-3184
INFORMANT EDWARD J. WENDEL Address 331 YOAKUM AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA — INTERVAL BETWEEN ONSET AND DEATH 2 DAYS

1.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) LAENNEC'S CIRRHOSIS — UNKNOWN

DUE TO (c) CHRONIC ALCOHOLISM — 25 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUGUST 13, 1959, to SEPT. 26, 1959, that I last saw the deceased alive on SEPT. 26, 1959, and that death occurred at 4.25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE George Bercu M.D. ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE DATE SIGNED 9/26/59.

PHYSICIAN'S NAME (Type) DR. GEORGE BERCU HAGERSTOWN, MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 9-29-59
22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM
22d. LOCATION (City, town or county) BROOKLYN (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE Doppel Bros ADDRESS 7110 Belair Rd
24a. REC'D BY REGISTRAR DATE SEP 29 '59
24b. REGISTRAR'S SIGNATURE Cathryn L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10775

CERTIFICATE OF DEATH

11940

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEAVER CREEK, RURAL
c. LENGTH OF STAY IN 1b: 28 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HAGERSTOWN MD. R.1

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BEAVER CREEK - RURAL
d. STREET ADDRESS: HAGERSTOWN MD. R.1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First HUBERT Middle B. Last WINDERS

4. DATE OF DEATH: Month SEPTEMBER Day 30 Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: AUG. 15. 1896
9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months 1 Days 15 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM
11. BIRTHPLACE (State or foreign country): MT. LENA WASH. Co. MD. U.S.A
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE W. WINDERS
14. MOTHER'S MAIDEN NAME: MARTHA KREBS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W. I
16. SOCIAL SECURITY NO: 215-36-7210
INFORMANT: MRS CHARLES W. MARTIN Address: HAGERSTOWN MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
332X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — 5 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-14-59, 19____, to 9-30-59, 19____, that I last saw the deceased alive on 9-21-59, 19____, and that death occurred at 11:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Hess, M.D. ADDRESS (Street, city or town, state): Smithsburg, Md. DATE SIGNED: 10-2-59

PHYSICIAN'S NAME (Type): Charles F. Hess, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 3-1959
22c. NAME OF CEMETERY OR CREMATORY: BEAVER CREEK CEMETERY
22d. LOCATION (City, town, or county) (State): BEAVER CREEK WASH. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John D Bast ADDRESS: BOONSBORO MD.
24a. REC'D BY REGISTRAR DATE: OCT 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10756

10759

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: Hag Rescue Mission
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle LUTHER Last WISHARD

4. DATE OF DEATH: Month Sept Day 30 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept 7 1903

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Hag Rescue Mission
11. BIRTHPLACE (State or foreign country): Cearfoss Wash Co Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John I. Wishard
14. MOTHER'S MAIDEN NAME: Alice M. Trumpower

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO: 216-22-1648
17. INFORMANT: Glenn Wishard
Address: 746 W. Wash St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of Liver
DUE TO (b): 152.7
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ———
INTERVAL BETWEEN ONSET AND DEATH: c / 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour ___ a. m. p. m. Month ___ Day ___ Year 19___
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 28 19 14 to Sept 30 19 59 that I last saw the deceased alive on Sept 28 19 59, and that death occurred at 11 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J H Beachley M.D. ADDRESS (Street, city or town, state): Hagerstown Md. DATE SIGNED: Sept 30 59

PHYSICIAN'S NAME (Type): J H Beachley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10/2/59
22c. NAME OF CEMETERY OR CREMATORY: Mt Tabor Luth Cemetery
22d LOCATION (City, town, or county) (State): Fairview Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman
ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: OCT 5 2 '59
24b REGISTRAR'S SIGNATURE: ———

OCT 2 '59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10760 **CERTIFICATE OF DEATH** Reg. Dist. No. 10757

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown (Rural)
d. STREET ADDRESS: Maugansville Box 104
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

099

3. NAME OF DECEASED (Type or print): First INGER — Middle MARIE — Last WOLFFSEN

4. DATE OF DEATH: Month Sept. — Day 3 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 25, 1897

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Denmark

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Julius Pedersen

14. MOTHER'S MAIDEN NAME: Thora Mortensen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-14-1357

INFORMANT Address: Mr. H. C. L. Wolffsen Box 104 Maugansville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hr

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 28, 1959, to Mar 6, 1959, that I last saw the deceased alive on Mar 6, 1959, and that death occurred at 1 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert V. L. Campbell M.D. — ADDRESS (Street, city or town, state): 145 W Washington St — DATE SIGNED: 9/4/59

PHYSICIAN'S NAME (Type): Robert V. L. Campbell — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/5/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE SEP 8 '59

24b. REGISTRAR'S SIGNATURE: Chester L Kraus

Wm. A. Host V-Pres.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10761

CERTIFICATE OF DEATH

10758

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 343 So Potomac St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ADA — Middle LA MAR — Last YOUNG

4. DATE OF DEATH: Month Sept — Day 28 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 16 1881

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Wash Co Md. Lappans Cross Road

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Marene LaMar

14. MOTHER'S MAIDEN NAME: Anna M. Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-38-1733

17. INFORMANT — Address: Walter Young 343 So Potomac st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO: (Left ventricular failure)
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease — 3 years.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Bronchial Asthma.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 5, 19 56 to Sept. 28, 19 59 that I last saw the deceased alive on Sept. 27, 19 59, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Bell M.D.
ADDRESS (Street, city or town, state): 119 N. Potomac Street, Hagerstown, Maryland.
DATE SIGNED: 9-30-59

PHYSICIAN'S NAME (Type): R.A.Bell, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/30/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR — DATE: OCT 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause